



SIM

Quality Metrics

Work Group

December 14, 2015

Agenda



- Introductions
- Brief SIM Overview
- CareFirst Quality Measures
- Discussion on Measure Selection Criteria
- Discussion on Candidate Measures

AIM

What are you trying to improve, by how much, and by when?

Improve health outcomes, experience of care, and value in health care spending for high-cost, high-need patients in D.C.

By 2020:

- 1) Significantly improve performance on selected health and wellness outcome quality measures and reduce disparities;
- 2) Reduce inappropriate utilization of inpatient and emergency department by 10% or meet DC Healthy People 2020 benchmark goal;
- 3) Reduce preventable readmission rates by 10% or meet DC Healthy People 2020 benchmark goal;
- 4) Better align overall health spending and re-invest savings towards prevention and addressing housing and other social determinants of health; and
- 5) Develop a continuous learning health system that supports more timely, efficient, and higher-value health care throughout the care continuum.

Primary Driver

What are the major categories of effort that will help achieve the aim(s)?
(Note: may impact multiple aims)

Support value-based payment models that reward quality, improved health and efficiency

Invest in capacity building infrastructure and supports to assist providers as they change their business model and workflows

Strengthen data exchange infrastructure to inform clinical and social services, measure performance, and engage patients

Improve and integrate coordination of health care and social services with an enhanced focus on high-need patients

Secondary Driver

What specific activities will be done to help achieve the primary driver? (Note: may impact multiple aims)

Develop personalized and integrated interventions for high-need patients that address social determinants of health

Identify or develop, monitor, and align health and wellness quality measures

Establish alternative payment model(s) that incentivize and improve provider accountability and outcomes

Provide an upfront investment to transform organizational structures

Recruit, retain, and continuously develop a workforce that meets the needs of all District residents and accelerates the integration of evidence-based knowledge in their practice

Incentivize providers to invest in EHR/HIE/data analytic tools and effectively utilize data for population health and quality improvements

Integrate data across Agencies in order to incorporate data into clinical workflow and for analysis by gov't agencies

Link PCPs, specialists, community-based providers, and social service providers to reduce avoidable hospital and ER use

Reward coordination of health and social services within payment model(s)

DC High-Cost, High Need SIM Driver Diagram

SIM to Support Short and Long Term Health Reform and Innovation Goals



Short Term Goal:

Implement a Chronic Condition Health Home that integrates and coordinates primary, acute, behavioral health, and long-term services and supports to treat the whole person for individuals with 2+ chronic conditions (or 1+ condition and chronically homeless)

Long Term Goal:

Transform the payment/delivery system in the District over the next five to ten years; move away from fee-for-service payment and towards care delivery and payment models that promote better outcomes

Quality Metrics Work Group

Mandate

- The Quality Metrics Work Group will develop recommendations for the Advisory Committee to design a plan that would seek to streamline quality reporting across all District payers; promote agreement on a shared set of measures; identify quality report infrastructure needs; and strategies for quality improvement.

Key Questions for Work Group Recommendations

- How does the District promote more coordinated and streamlined quality reporting?
- What measures are needed to evaluate improved outcomes for specific target populations?
- What options are available to promote a quality reporting data infrastructure?
- What infrastructure do providers need to report quality measures?
- How does the District spread the reporting of existing quality measures to more practices?
- What are the specific metrics required to support the proposed payment model?

Discussion

- ❖ What criteria should we use to select measures?
 - ❖ Not only for DC specific health home measures, but develop a shared set shared set of measures that would improve outcomes.
- ❖ From first glance of the matrix:
 - ❖ Are there measures or domains, missing?
 - ❖ Which measures should be considered?

Criteria Selection Common Themes

- Current Feasibility
- Evidence-based and Scientifically Acceptable
- Setting Free
- Usability / Adaptability
- Patient Experience
- Has a Relevant Benchmark
- Financial / Incentivization
- Improving this Measure will Translate into Significant Changes in Value
- Durability
- Aligned with Other Measure Sets

Health Home Core Measures

Measure
Controlling High Blood Pressure
Follow-Up After Hospitalization for Mental Illness
Plan All-Cause Readmission
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Screening for Clinical Depression and Follow-Up Plan
Adult Body Mass Index (BMI) Assessment
Care Transition Record Transmitted to Health Care Professional
Prevention Quality Indicators #92: Chronic Conditions Composite
Emergency Department Visits
Inpatient Utilization
Nursing Facility Utilization